UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Serenity Health Chiropractic
60 2nd St., Unit C-7
Shalimar, FL 32579
PH: 850-613-4125
Fax: 850-613-4148
serenityhealthchirorpactic.com

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Age

Birth Date (MM/DD/YYYY)

Gender
◯ Male ◯ Female

Your Last Name

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

Preferred Language

City

State/Province

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?
◯ Yes ◯ No

City

State/Province

ZIP/Postal Code

Preferred method of contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Primary Care Provider's Name

I certify that any changes to my personal information have been updated above for your records. ____________________
Signature

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UPDATED PATIENT HISTORY

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◯ **I have new contact information**

Today's Date (MM/DD/YYYY) ____________

Patient Number (office use only) ____________

Your Last Name ____________ **Your First Name** ____________ **Your Middle Name (or Initial)** ____________

Please select one:

◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
◯ **New condition** – I've been under care and a new or returning condition has emerged.
◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ____________

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other ____________
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ____________

Onset (When did you first notice your current symptoms?) ____________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ____________

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ____________

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other ____________
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ____________

Onset (When did you first notice your current symptoms?) ____________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ____________

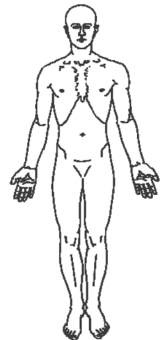
Additional Complaint
The additional symptom that prompted me to seek care today is: ____________

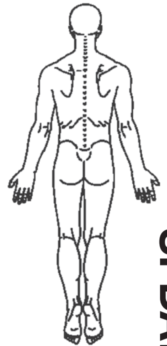
And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other ____________
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other ____________

Onset (When did you first notice your current symptoms?) ____________

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other ____________

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past





1. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. **Musculoskeletal System** – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. **Neurological System** – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. **Cardiovascular System** – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. **Respiratory System** – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. **Digestive System** – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. **Sensory System** – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. **Skin System** – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. **Endocrine System**– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. **Genitourinary System** – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. **Constitutional System** – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

Doctor's Initials ____________

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Patient name

Patient Number
(office use only)

2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: ______________________

3. Medications (please list all prescription and over-the-counter): ______________________

4. Social History (Tell Serenity Health Chiropractic about your health habits and stress levels.)

Alcohol use	◯ Daily	◯ Weekly	How much?____________
Coffee use	◯ Daily	◯ Weekly	How much?____________
Tobacco use	◯ Daily	◯ Weekly	How much?____________
Exercising	◯ Daily	◯ Weekly	How much?____________
Pain relievers	◯ Daily	◯ Weekly	How much?____________
Soft drinks	◯ Daily	◯ Weekly	How much?____________
Water intake	◯ Daily	◯ Weekly	How much?____________

Hobbies: ______________________

Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

5. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

6. Is there anything else Serenity Health Chiropractic should know about your current condition, your progress or ways your current condition is affecting your life?

____

Consultation Notes

Patient (or Guardian's) signature ______________ Date (MM/DD/YYYY) ______________

Doctor's Initials

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